COMMONWEALTH OF VIRGINIA
Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER (ACTING)

OFFICE OF ADJUDICATION

DOUGLAS R. HARRIS, J.D.

RECOMMENDATION TO THE STATE HEALTH COMMISSIONER REGARDING

CERTIFICATE OF PUBLIC NEED (COPN)
REQUEST NUMBER VA-6586
Bon Secours Memorial Regional Medical and
Memorial Ambulatory Surgery Center
County of Hanover
Establish a Six-Operating Room Outpatient Surgical Hospital,

and

COPN REQUEST NUMBER VA-6601
Virginia Commonwealth University Health System Authority,
Medical College of Virginia Hospitals
City of Richmond
Addition of Four Operating Rooms

A. FINDINGS OF FACT

1. In August 2001, Bon Secours Memorial Regional Medical Center, Inc. (MRMC), and Memorial Ambulatory Surgical Center, L.L.C., together as co-applicants, applied for a certificate of public need (COPN) seeking authorization to establish a six-operating room (OR) outpatient surgical hospital on the campus of Hanover Medical Park in Hanover County, Planning District (PD) 15, Health Planning Region (HPR) IV. The outpatient surgical hospital would be located in a medical office building to be owned by a private commercial real estate developer with experience in the development and management of medical office buildings and medical care facilities. The total capital cost of the project proposed by MRMC is $475,000.

2. In that same month, the Virginia Commonwealth University Health System Authority (VCUHSA) applied for a COPN seeking authorization to add four ORs on the campus of the Medical College of Virginia Hospitals (MCVH) in the City of Richmond, which is located in the same PD and HPR. The total capital cost of the project proposed by VCUHSA is $590,800.

3. Sections 32.1-102.1 and 32.1-102.3 of the Code of Virginia require that "[a]n increase in the total number of . . . operating rooms [ORs] in an existing medical facility" by or in behalf of a medical care facility" must be approved by the State Health Commissioner through issuance of a COPN.

4. Because these two applications were filed in the same "batch," or review cycle, and since they propose the same or similar services and facilities in the same planning district, they are "competing applications," as defined in 12 VAC 5-220-10, and must be reviewed together and in accordance with standards devised for reviewing competing applications.

5. The Central Virginia Health Planning Agency (CVHPA) serves HPR IV by reviewing "projects," as defined in Section 32.1-102.1 of the Virginia Code, proposed for location within the boundaries of HPR IV.

6. MRMC is owned by Bon Secours Richmond Health System, a Virginia non-stock, non-profit corporation. Memorial Ambulatory Surgical Center, MRMC's co-applicant, is a Virginia limited liability company, of which MRMC has a controlling membership. Another Virginia limited liability company, to be owned by involved surgeons, will have a remaining membership in Memorial Ambulatory Surgical Center.

7. MRMC is a 225-bed acute care hospital equipped with nine ORs, one of which is dedicated to cardiac surgery. MRMC is located within a half-mile of Interstate 295. Since opening on May 30, 1998, MRMC has become an important provider of medical services in PD 15 as the number of persons seeking services and the number of physicians seeking staff privileges there has increased dramatically.

8. VCUHSA is a political subdivision of the Commonwealth that was created by the enactment of the Medical College of Virginia Hospitals Authority Act, now known as the Virginia Commonwealth University Health System Authority Act, Section 23-50.16:1 *et seq*. of the Virginia Code. VCUHSA owns and operates MCVH – an academic, regional tertiary teaching hospital licensed for 786 beds with an extensive urban campus located in the City of Richmond. MCVH provides a broad array of clinical, medical, surgical and diagnostic services to patients living throughout the Commonwealth and beyond.

9. Virginia regulation, *viz.*, Chapter 270 of the State Medical Facilities Plan (SMFP) 12 VAC 5-270-10 *et seq*., contains standards and provisions with which the Commissioner may review applications for the addition of surgical services, or ORs.

10. In September 1999, the State Board of Health adopted emergency regulations specifically required by Virginia law enacted that year, *viz.*, Senate Bill 1282, and House Bills 2369 and 2543.

Among other things, these bills required the Board of Health to adopt regulations "establish[ing] specific criteria for determining need in rural areas, giving due consideration to distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care in such areas. . . ." Under Section 2.2-4011 of the Virginia Code, emergency regulations may remain effective for a maximum of twelve months. The Board's 1999 emergency regulations, effective from January 3, 2000, to January 2, 2001, sought to amend the regulations governing the process by which the Department of Health reviews applications for COPNs and to amend the SMFP. Among other things, the Board sought to implement an amendment of 12 VAC 5-230-270 A, which addresses the need for operating room capacity. In that section, the Board's emergency regulation codified the consideration of

> the addition of operating rooms by existing medical care facilities in planning districts with an excess supply of operating rooms . . . when such addition can be justified on the basis of *facility-specific utilization*, geographic remoteness or both . . . . [Emphasis added.]

11. Although the emergency regulation containing the provision noted directly above was not in effect when MRMC and VCU submitted their applications seeking additional operating rooms in PD 15, statutory law clearly provides an authorizing basis on which public need in rural areas and institutional need may be legitimately considered in reviewing applications for COPNs. Further, the institutional need provision was adopted as an emergency regulations in order to codify the existing policy of the Commissioner that facility-specific need is a relevant consideration in making a determination of public need.

12. To illustrate, at least three of the Commissioner's decisions to issue COPNs approving additional ORs in HPR V and elsewhere made since 1998 have relied, in part, on the existence of institutional need. The Commissioner has issued other applications based similarly on institutional need. Notably, the Board of Health has begun and is continuing to carry out the regulatory process, prescribed by the Administrative Process Act, Virginia Code Section 2.2-4000 *et seq*., necessary to make permanent the provisions of the 1999 emergency regulations.

13. In a January 30, 2002, decision authorizing additional surgical capacity at Danville Memorial Regional Hospital, based primarily on the demonstrated existence of institutional need at that facility, as evinced by the high utilization of existing ORs, the Commissioner observed that "[t]he COPN program was never intended and is not designed to impede successful facilities in their efforts to care effectively for current and anticipated patients."

14. In 1999, MCVH ranked first in HPR IV and in Virginia for its contribution to charity care, expressed both as a total figure and as a percent of gross patient revenues. It provided $120,371,479 in charity care, amounting to 17.2 percent of its gross patient revenues. In 1999, MRMC provided a level of charity care equaling 0.3 percent of gross patient revenues. The median charity care contribution for the 18 acute care general hospitals in HPR IV was 0.7 percent of gross patient revenues.

Charity Care Percentage of Gross Patient Revenue in Health Planning Region IV, 1998 and 1999

Facility	1998	1999
Medical College of Virginia Hospital	***17.5***	***17.2***
Southside Community Hospital	3.1	3.2
Community Memorial Healthcenter	3.4	2.6
Bon Secours-Richmond Community Hospital	0.4	2.0
Southside Regional Medical Center	1.7	1.5
Halifax Regional Hospital	1.6	1.5
Children's Hospital	1.2	1.0
Capitol Medical Center***	0.7	0.8
HCA-John Randolph Hospital	0.7	0.7
Bon Secours-Stuart Circle Hospital	0.8	0.6
Bon Secours-St. Mary's Hospital	0.5	0.5
Richmond Eye & Ear Hospital	0.3	0.5
HCA-Retreat Hospital	0.6	0.5
HCA-Chippenham & Johnston-Willis Hospitals	0.7	0.3
HCA-Henrico Doctors' Hospital	0.4	0.3
Bon Secours-Memorial Regional Medical Center*	***n/a***	***0.3***
HealthSouth Medical Center**	0.0	0.0
Greensville Memorial Hospital	2.1	n/a
Bon Secours-Richmond Memorial Hospital***	0.5	n/a
HPR Median	***0.7***	***0.7***

* Opened in 1999
** Purchased by HCA in 2001
*** Recently Closed

15. CVHPA states that VCUHSA provides nearly 31 percent of the charity care in Virginia.

16. CVHPA's calculations of the median percentage deviate from the Department's insofar as CVHPA identifies a median percentage of charity care provided in PD 15 of 0.8 percent in 1999 and 0.9 for HPR IV in 1999. CVHPA calculates the mean, or average, percentage of charity care provided in PD 15 to be 2.2 percent in 1999 and to be 2.1 percent for HPR IV in the same year.

17. CVHPA recommends conditional approval, as detailed below, of the application submitted by MRMC and approval outright of the application submitted by VCU. At the public hearing held by CVHPA to discuss the two applications, several persons spoke in favor of one or the other application. The chairman of the Hanover County Board of Supervisors spoke in favor of the MRMC proposal to build an outpatient surgical center, and noted that several senior citizens homes are under construction near Hanover Medical Park. One person, representing the interests of Retreat Hospital, has written in opposition to the MRMC application, and attempted to assert a "good cause challenge," as discussed below. No one has voiced opposition to the VCU application.

18. By letter dated November 19, 2001, the Department of Health, Division of Certificate of Public Need (DCOPN), notified MRMC and VCUHSA that DCOPN recommends denial of MRMC's application and approval of VCUHSA's application.

19. Retreat Hospital, one of five hospitals located in the Richmond metropolitan area owned by the Hospital Corporation of America (HCA), owns and operates the Hanover Outpatient Center, a 2-OR outpatient surgical center in Hanover County currently operating at 113 percent of the regulatory

standard used to gauge OR utilization, and perhaps at a substantially higher level if contested data, clearly specified in a routine application for license renewal submitted by Retreat's outpatient center and indicating a utilization level of 194 percent, are accurate.

20. On November 21, 2001, and pursuant to Sections 32.1-102.6 (D) and (G) of the Virginia Code, Retreat Hospital submitted a written petition to establish good cause to be a party to an informal-fact finding conference (IFFC) scheduled to discuss the MRMC application, as well as the VCU application. Retreat based its petition on an alleged "substantial material mistake of fact" in the DCOPN staff report on MRMC's application – one of three bases on which such be petition may be brought. Following clarifying correspondence from DCOPN, Retreat chose, on December 3, 2001, to withdraw its petition, while reiterating its general opposition to MRMC's application.

21. Although not a party to the IFFC, Retreat Hospital's Hanover Outpatient Surgery Center chose, after withdrawing its good cause petition, to submit the unsolicited analysis of the MRMC proposal, prepared by a consultant, in which Retreat alleges that (i) MRMC's identified service area was incorrectly identified and exaggerated the purported need for the project, (ii) MRMC had failed to efficiently utilize its existing suite of ORs, and (iii) charges at an outpatient surgery center owned and operated by the Bon Secours Richmond Health System – Ironbridge Outpatient Surgical Center – are high, suggesting that charges at the proposed outpatient surgical hospital would be high.

22. The application submitted by VCUHSA has received a recommendation of approval from CVHPA and DCOPN, due mainly to a demonstrated institutional need, as evinced by its 20 ORs operating at a level equaling 155 percent of the applicable OR utilization standard. No person has voiced opposition to VCUHSA's application. MRMC, which by applicable regulatory definition, is competing with VCUHSA for surgical services, has clearly stated that it is not opposing VCUHSA's application. At the IFFC, MRMC stated that "often in [COPN IFFCs] competing applicants challenge one another's projects. That is not the case in this proceeding. . . . [VCUHSA] has demonstrated an institutional need for its project."

23. An IFFC was convened on December 5, 2001, in Richmond pursuant to Sections 2.2-4019 and 32.1-102.6 of the Virginia Code to discuss this application. VCU and MRMC were represented by counsel at the IFFC.

B. DISCUSSION OF THE APPLICATIONS IN RELATION TO THE LAW

Virginia Code Section 32.1-102.3 B requires that, in determining whether a public need for a proposed project has been demonstrated, the State Health Commissioner shall review an application for a certificate of public need in relation to the twenty considerations enumerated in that section. The following is a discussion of the applications in relation to these considerations.

I. Summary Recommendation Regarding VCUHSA

The application submitted by VCUHSA to add four ORs at MCVH has received favorable recommendations from both CVHPA and DCOPN, and enjoys substantial support, with no known opposition, among interested persons. The record clearly shows an institutional need for this project, which, if approved, would restore a previous level of surgical capacity – totaling 24 ORs – at MCVH,

a hospital with a unique and broad teaching mission and a highly commendable commitment to charity care. The 20 ORs currently authorized and active at MCVH are operating at 155 percent of the applicable utilization standard, and the total capital cost of the proposed project to add four ORs – $590,800 – is highly reasonable.

Pursuant to 12 VAC 5-220-230 (A), the Department of Health conduct IFFCs on COPN applications when necessary. When received without competing applications, an application for a COPN is not, in the usual course of regulatory review and administrative process, referred to the Department's Office of Adjudication for an IFFC unless (i) either the health planning agency involved or DCOPN has, or both have, made a negative recommendation regarding the application, or (ii) the Commissioner has specifically directed that the application become the subject of an IFFC to be conducted by the Office of Adjudication. Similarly, an application submitted in a competitive batch is not, in the usual course of regulatory review and administrative process, referred to the Office of Adjudication for an IFFC unless (i) either the health planning agency involved or DCOPN has, or both have, made a negative recommendation regarding the instant application or a competing application, or (ii) the Commissioner has specifically directed that the instant application or a competing application be referred to the Office of Adjudication for an IFFC.

I have reviewed the record relating to the VCUHSA application and agree that it would address a substantial, demonstrated institutional need for surgical capacity at MCVH and would be consistent with recent decisions made by the Commissioner. Despite the existence of a numerical surplus of ORs in PD 15, discussed in detail below, the institutional need of MCVH – the largest and busiest hospital in the area, justifies an approval of that hospital's proposed projects to add surgical capacity. Inasmuch as the VCUHSA application appears to merit approval by proposing a project based on institutional need and inasmuch as it became a subject of an IFFC precisely and solely because DCOPN made a negative recommendation regarding the competing application of MRMC, I propose hereby to make **a summary recommendation that the application from VCUHSA be approved based on the weight of evidence in the record and that a COPN be issued authorizing the project proposed in that application.**

Accordingly, the following discussion will involve only the application submitted by MRMC. If, however, the Commissioner desires a fuller discussion of VCUHSA's application and proposed project, this adjudication officer would gladly oblige.

II. Discussion Regarding MRMC

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

The Board of Directors of CVHPA voted 11 to three, with three abstentions, to recommend approval of the MRMC application to establish a six-OR outpatient surgery center, conditioned on MRMC's willingness to commit the equivalent of two percent of the gross patient revenues derived from the proposed outpatient surgery center to charity care. By letter dated November 8, 2001, MRMC agreed to the imposition of such a condition, should the Commissioner issue a COPN authorizing the proposed project.

2. The relationship of the project to the applicable health plans of the regional health planning agency, the Virginia Health Planning Board and the Board of Health.

The applicable health plan is Part II of Chapter 270 of the State Medical Facilities Plan (SMFP), found at 12 VAC 5-270-10 *et seq*. (Text appearing under this consideration in italics has been selected from the SMFP and precedes discussion of the proposed project in relation to the selected text.)

12 VAC 5-270-20. Acceptability. Self-referral. Surgical services providers should comply with all applicable federal and state statutes governing the ability of physicians to refer patients to facilities in which they have an ownership interest.

At least 51 percent of the limited liability company devised to own and operate the proposed outpatient surgical hospital – Memorial Ambulatory Surgery Center, L.L.C. – would be owned by MRMC. The remainder of the owning company, not exceeding 49 percent, would be owned by another limited liability company owned by numerous physicians.

The applicants have provided assurances that every physician with an ownership interest in the proposed project will be expected to comply with all federal and state laws and regulations that would govern the ability of physicians to refer patients to the proposed outpatient surgery center.

12 VAC 5-270-30. Accessibility; travel time; financial. Surgical services should be available within a maximum driving time, under normal conditions, of 45 minutes for 90 percent of the population.

Surgical facilities are clearly available within 45 minutes' driving time for 90 percent of the population to be served. PD 15 has 21 general hospitals and eight outpatient surgical hospitals. MRMC points out, however, that residents of Hanover County have far fewer ORs available to them in their own locality then do other residents of PD 15.

Surgical services should be accessible to all patients in need of services without regard to their ability to pay or the payment source.

MRMC provided the equivalent of 0.3 percent of its gross patient revenues to charity care in 1999, and is willing to commit the equivalent of two percent of the gross patient revenues derived from the proposed outpatient surgical hospital to charity care. Data available after the review process had been completed indicate that MRMC provided 0.4 percent of gross patient revenue to charity care in 2000.

12 VAC 5-270-40. Availability; need. A. Need. The combined number of inpatient and ambulatory surgical operating rooms needed in a planning district will be determined . . . [according to the computational methodology set forth in this provision, which includes factors such as (i) recent operating room utilization, (ii) recent and projected population, and (iii) the average length of operating room visits].

No additional operating rooms should be authorized for a planning district if the number of existing or authorized operating rooms in the planning district is greater than the need for operating rooms identified using . . . [this] methodology. New operating rooms may be authorized for a planning

district up to the net need identified by subtracting the number of existing or authorized operating rooms in the planning district from the future operating rooms needed in the planning district, as identified using the [methodology set forth in this subsection].

Like many provisions of the SMFP, this one seeks to ensure that ORs in a PD are optimally utilized and that facilities do not undertake capital investments which would not be used efficiently in serving public need for surgical services.

In reviewing these applications, both CVHPA and DCOPN used available data that indicate a total of 146 ORs serving PD 15. CVHPA noted, however, that two of these ORs, located at Children's Hospital in Richmond, are not active and an additional three ORs, formerly located at Capital Medical Center in Richmond, have been removed from the active inventory through closure of that facility. Consequently, a total of 141 ORs appear to serve PD 15. Notably, fifteen of the total number of ORs are located in outpatient surgical hospitals, also know as ambulatory surgery centers. At least seven and perhaps 13 of the total number of ORs in PD 15 are located in specialized medical facilities that serve a narrow category of surgical patients, are not likely to have the capabilities to serve general surgical patients, and generally experience low utilization. Despite these additional attenuations, data created by DCOPN using the methodology set out in the SMFP indicate that PD 15 will need a total of 128 ORs in 2004, thereby suggesting a current numerical surplus of 13 ORs, or ten percent, for PD 15.

Despite the existence of a numerical surplus of ORs in PD 15 and the recommended approval of a four-OR addition at MCVH, however, an institutional need of MRMC may justify an approval of that hospital's proposed projects to add surgical capacity.

MRMC is a new, well-conceived and rapidly growing facility located in Hanover County. Since opening in 1998, it has experienced a 40 percent increase in inpatient surgical procedures and a nearly 63 percent increase in outpatient surgical procedures. This growth, along with the utilization rate of MRMC's existing ORs, discussed below, may indicate an institutional need for surgical capacity. As noted above, several recent approvals of applications for COPNs recognize that, despite the existence of a numerical surplus within a particular PD, as calculated using the methodology of the SMFP, an individual facility's need may justify expansion of OR capacity. These decisions reflect the reality that excess surgical capacity in a PD does not adequately compensate for need experienced at a particularly well-utilized facility. If a compelling institutional need has been identified at MRMC, its application may be consistent with these recent decisions, in which similarly-situated hospitals received authority for additional surgical capacity.

MRMC appears to have an identifiable institutional need for additional operating capacity. The utilization of MRMC's nine ORs has grown considerably since 1998. MRMC's nine general purpose ORs performed 15,568 surgical hours in 2001, which would equate to the use of nearly ten general purpose ORs based on the 1,600-hour standard and to a utilization rate of over 108 percent. (Additionally, one of MRMC's ORs is reserved for cardiac patients; if the current volume of surgery performed at MRMC is correlated to the remaining eight ORs, the utilization rate at MRMC appears to be over 121 percent.)

From 1999 to 2000, the number of surgical hours performed at MRMC increased 16 percent, from 11,385 to 13,238. From 2000 to 2001, the number of surgical hours increased 17 percent, from

13,238 to 15,568. For the purpose of illustration and if, for the sake of conservatism, an average annual rate of growth of 10 percent is projected to occur in ensuing years, the following utilization figures would prevail at MRMC.

Projected OR Utilization at MRMC, Assuming a 10 Percent Annual Increase

Year	Total Surgical Hours	Corresponding Number of ORs*	Percentage Utilization**
2002	17,125	10.7	119
2003	18,837	11.8	131
2004	20,721	13.0	144
2005	22,793	14.2	158

*Based on 1,600 hours per OR per year
** Assuming retention of the present total of nine ORs

MRMC anticipates a continuing "rapid ramping up" of surgical utilization, and similarly projects that its nine ORs will perform 18,850 surgical hours in 2003, which would equate to the use of 12 ORs and to a utilization rate of nearly 131 percent of the standard. Further, MRMC projects that in 2005, its ORs will perform 23,212 surgical hours equating to the use of 15 ORs and to a utilization rate of 161 percent. In light of these projections, and the considerable growth in surgical activity at MRMC since 1998 – especially outpatient surgery patients, its application appears reasonably designed to accommodate projected growth.

12 VAC 5-270-50. Cost; charges. [This provision allows the creation of a preference among competing applications when a deficit of surgical services has been identified in a PD and is not applicable.]

12 VAC5-270-60. Quality; accreditation/licensure. A. Surgical services providers should meet all applicable accreditation standards of the Joint Commission on the Accreditation of Healthcare Organizations or the Association for Accreditation of Ambulatory Health Centers and licensure standards of the Department of Health.

MRMC maintains accreditation through the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and appears to comply with applicable licensure standards of the Department of Health. MRMC has given assurances that the proposed outpatient surgical hospital would similarly maintain accreditation and compliance.

B. Existing and proposed providers of surgical services should document the availability of physicians who are board-certified or board-eligible in appropriate surgical specialties.

MRMC currently has on staff physicians who are board-certified or board-eligible in all general surgical specialties and subspecialties, and has given assurances that the proposed facility would adopt substantially similar credentialing criteria to govern the extension of surgical privileges to members of its medical staff.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

As a new facility, the proposed ambulatory surgery center does not have a long range plan in place. The project is, however, consistent with MRMC's stated goal of accommodating the community's growing need for surgical services.

4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

In a post-IFFC submission, MRMC observed that

> [i]n 1973 the General Assembly enacted Virginia's first Medical Care Facilities Certificate of Public Need Law 'to promote comprehensive health planning in order to meet the health care needs of the public' and to achieve other stated goals. *See* Va. Code Section 32-211.4 (Supp. 1973); *see also* Acts of Assembly, 1973, c. 419. While the past twenty-eight years have witnessed expansions and contractions of this law's regulatory ambit, the law has always had as its stated purpose the promotion of health care services to meet the needs of . . . [the public]. The establishment of an ambulatory surgery center on the campus of Hanover Medical Park is fully consistent with such purpose.

And of its application specifically, MRMC asserts that

> [MRMC's] existing general purpose operating rooms currently are utilized at a level that exceeds the 1600 hour standard contemplated by the [SMFP]. As the population seeking surgical services at the hospital increases, the demands placed on the existing [ORs] will only increase more, and result in greater stresses on patients and hospital staff. As scheduling difficulties increase, physicians will be forced to schedule more procedures into the evening hours and patients will be forced to remain without food and water for longer periods of time in preparation for surgery. To alleviate some of the current demand placed on [MRMC] and ensure continued access to surgical facilities for patients and their physicians, additional operating rooms must be established on the campus of Hanover Medical Park. The proposed project will address this public need and ensure that public demand for surgical services, as expressed on the Hanover Medical Park campus, continues to be met.

At the IFFC, MRMC's vice president of surgical services testified that two-thirds of MRMC's ORs are operating beyond an eight-hour day, that this level of utilization results in physicians' frustration and morale issues for staff who must remain on duty beyond scheduled hours to assist with surgeries, that emergency surgery cases sometimes cause scheduled cases to be delayed, to the discomfort of waiting patients, and that surgical patients cannot readily be transferred to other hospitals within the Bon Secours Richmond Health System.

As discussed above, although not a party to the IFFC, Retreat Hospital's Hanover Outpatient Surgery Center chose, after withdrawing its good cause petition, to submit the unsolicited analysis of the MRMC proposal, prepared by a consultant, in which Retreat alleges, among other things, that

MRMC's identified service area was incorrectly identified and exaggerated the purported need for the project, purporting to characterize it as "badly flawed." This contention is specious, however, insofar as the methodology followed by MRMC to determine service area was reasonable, conventional and in accordance with applicable regulations.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

The proposed outpatient surgery center would be located on the campus of Hanover Medical Park, in Hanover County, approximately one-half mile from Interstate 295; it would be highly accessible by highway to area residents.

In 2000, MRMC provided a level of charity care equivalent to 0.4 percent of total patient revenue. MRMC has agreed to commit the equivalent of two percent of the gross patient revenues derived from the proposed outpatient surgery center to charity care.

An outpatient surgical hospital, often referred to as an ambulatory surgery center, typically provides better access for surgical outpatients than surgical facilities in an inpatient setting, due to accommodating features of design and due to the elimination of scheduling delays caused by surgical complications and the need to take emergency cases to surgery. Such a facility can avoid the confusion often encountered by outpatients seeking surgical services in an inpatient setting of an acute care hospital, while liberating inpatient surgical resources for patients needing procedures involving greater surgical acuity. Parking is often more convenient. Such a facility can be designed specifically to meet the needs and expectations of surgical outpatients.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

A well developed system of Interstate and other major highways serves the central Virginia area, making travel by road convenient. The population of PD 15 grew significantly over the last ten years, and totaled 865,941 in 2000.

The proposed project would be situated in Hanover County – the ninth most populous conty in the Commonwealth. The 2000 U.S. Census indicates that Hanover County experienced a growth rate of 36.4 percent from 1990 to 2000, and includes 86,320 residents. The Virginia Employment Commission (VEC) projects that the population of Hanover County will increase by over 10 percent by 2004. Similarly, New Kent County, directly to the east, should experience a 10 percent increase in population during this period.

Henrico and Chesterfield counties – the third and fourth most populous counties in Virginia, experienced a growth rate of 20.4 and 24.2 percent from 1990 to 2000 and include 262,300 and 259,903 residents, respectively. The City of Richmond, within approximately five miles of Hanover Medical Park, includes an additional 197,790 residents.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

MRMC contends that the proposed outpatient surgical hospital promises benefits of efficiency and convenience insofar as it would create two streams of patients – one for inpatients, another for outpatients – each flowing through settings and procedures tailored to the needs of those patients. As noted above, the number of outpatient surgeries at MRMC has increased 63 percent since 1998. MRMC's vice president of surgical services noted at the IFFC that

> [w]hat we need is an area where we can streamline our outpatients. Our recovery room currently has some limitations, and when you . . . have inpatients and outpatients in the same facility, your inpatients tend to take up more time in your recovery room because of the acuity of the kinds of cases that you are doing. . . . [S]o if there was a way to split that up, you would have more capacity in a freestanding center because you are doing types of cases that are quick turnaround, quick recovery time, and . . . in an outpatient setting, . . . [a patient is] not going to get bumped for [emergencies]. . . . Our [current] recovery room does not have the capacity to increase outpatient volume because we just don't have the space for it.

Although not a party to the IFFC, Retreat Hospital's Hanover Outpatient Surgery Center challenges MRMC's proposed project, in part, by alleging that MRMC's existing suite of ORs is not utilized efficiently, citing an increase in inpatient hours per surgical case from 1.56 hours in 1999 to a projected 2.8 hours in 2005 (while outpatient hours per case would fall from 2.25 hours to 1.5 hours in 2005). Drawing a conclusion of inefficiency appears specious. The length of time required for each surgical procedure, whether inpatient or outpatient, varies considerably, according to the needs of the patient and the complexity of the case. An alternative conclusion might be drawn from increasing length of time for surgeries: A well-appointed, highly-developed inpatient surgical suite may attract more complex cases needing a higher level of surgical acuity.

8. The immediate and long-term financial feasibility of the project.

The MRMC project will be funded through a short term line of credit satisfied from operational income. The project appears financially feasible in the immediate and long-term. MRMC's pro forma financial statement projects a net income derived from the proposed outpatient surgical hospital following the first year of operation.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

HPR IV is served by 15 other hospitals, including MCVH – a large academic medical center. The proposed outpatient surgical hospital would be adjacent to MRMC, a well-developed contemporary hospital and a member of the Bon Secours Richmond Health System. CVHPA observed that the proposed outpatient surgical hospital "would offer a type of surgical care currently not provided in PD 15. No full-service, multi-specialty, on-campus, freestanding ambulatory surgical center exists in [PD 15]."

10. The availability of resources for the project.

Sufficient resources are available for the project; the entire $475,000 cost of establishing the outpatient surgical hospital would be funded through a short term line of credit to be satisfied with operational revenue.

11. The organizational relationship of the project to necessary ancillary and support services.

The proximity of the proposed outpatient surgical hospital to MRMC – a full-service, acute care hospital that is, itself, part of a wider facility network – would provide physicians and patients with nearly immediate access to ancillary and emergency services in the event they become necessary.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

Not applicable.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

In a post-IFFC submission, MRMC asserts that the primary service area contemplated by the proposed project "is comprised substantially of counties not located within the [HPR] in which the proposed [outpatient surgical hospital would] be located," including the counties of Essex, King William and Caroline. These counties are located in HPRs I and V, while the proposed project would be located in HPR IV, and their total 2000 population was 45,256. MRMC states that, between September 2000 and May 2001, 543 of its surgical patients came from these counties, adding to its institutional need for surgical capacity.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

Not applicable.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable.

16. In the case of a construction project, the costs and benefits of the proposed construction.

Establishment of the proposed project would benefit the growing population residing within the MRMC's identified service area with improved access to surgical services. The estimated costs – totaling $475,000 – are minimal and do not include the ongoing operating costs associated with the planned lease of the facility. The benefits of improving access to surgical services, making the services provided to surgical outpatients and inpatients more efficient and tailored to their different needs, and meeting the facility-specific need of a growing hospital and community, however, appear to outweigh the costs of establishing the outpatient facility.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

The cost per surgical procedure may increase as several outpatient surgical hospitals in the area are underutilized. CVHPA's analysis, however, indicates that the cost of one particular surgical procedure performed at MRMC, chosen for illustration, is the lowest of several major hospitals in the area and considerably lower than the charge levied at Retreat Hospital's Hanover Outpatient Center, MMRC's geographically-closest competitor.

Approval of the MRMC project could negatively affect utilization of and charges at Retreat Hospital's Hanover Outpatient Center if patients are drawn from this facility to MRMC's proposed facility; however, the high level of utilization prevailing at Retreat's outpatient center should mitigate against such an effect.

As discussed above, although not a party to the IFFC, Retreat Hospital's Hanover Outpatient Surgery Center chose, after withdrawing its good cause petition, to submit the unsolicited analysis of the MRMC proposal, prepared by a consultant, in which Retreat alleges, among other things, that charges at an outpatient surgery center owned and operated by the Bon Secours Richmond Health System – Ironbridge Outpatient Surgical Center – are high, suggesting that charges at the proposed outpatient surgical hospital would be high. The Ironbridge facility, located south of the James River in Chesterfield County, experiences very low surgical utilization. The charges at the proposed outpatient surgical hospital, to be located on the campus of an existing hospital experiencing growth in surgical demand, are likely to be considerably lower than those at a dissimilar outpatient facility, lacking a similar conveying mechanism that promises considerable utilization.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

Not applicable.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

DCOPN calculated the level of utilization prevailing among the inventory of ORs in PD 15 to be 88 percent of the 1,600 hour per OR per year standard. While this level of utilization ostensibly suggests the existence of opportunities for exploring ways to increase efficiency of currently-available resources, MRMC's need for ORs is facility-specific, or institutional, and its application portends possible benefits of efficiency and quality stemming from the proposed location of the outpatient surgical hospital on the Hanover Medical Campus and situated proximate to MRMC – a geographically-accessible, contemporary, full-service, acute care hospital experiencing considerable growth.

Further, as discussed above, the inventory of ORs in PD 15 identified by DCOPN included three ORs that have been physically dismantled, at least two ORs that are not currently active, fifteen ORs located in outpatient surgical hospitals, and at least seven and perhaps as many as 13 ORs located in specialized medical facilities that, by their very nature and purpose, serve a narrow category of surgical patients, are not likely to have the capabilities to serve general surgical patients, and generally experience low utilization. In light of these attenuating conditions, the reasonable and appropriate level of surgical utilization at facilities in PD 15 may be misleadingly deflated by the 88 percent utilization level earlier identified.

As noted above, although not a party to the IFFC, Retreat Hospital's Hanover Outpatient Surgery Center chose, after withdrawing its good cause petition, to submit the unsolicited analysis of the MRMC proposal, prepared by a consultant, in which Retreat alleges, among other things, that MRMC has failed to efficiently utilize its existing suite of ORs. The length of time required for surgical procedures varies according to the needs of patients and the complexity of the matter. The average length of time for a surgical procedure at MRMC is reasonable in relation to the average for all surgical resources in PD 15; data indicating a greater average length of time for a surgical procedure at MRMC may result from a large number of operations involving greater complexity occurring there. Notably, at the IFFC, MRMC represented that it has trained additional staff to ensure that the time between surgeries is limited.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

Not applicable.

C. RECOMMENDATION

I. Regarding VCUHSA

As detailed above, I reiterate here my summary recommendation that the application from the Virginia Commonwealth University Health System Authority (VCUHSA) be approved based on the weight of evidence in the record and that a COPN be issued authorizing the project proposed in that application.

II. Regarding MRMC

I have reviewed the application and subsequent submissions of Bon Secours Memorial Regional Medical Center, Inc. (MRMC), and Memorial Ambulatory Surgical Center, L.L.C. (MASC), together as co-applicants. I have heard from counsel to the applicants in support of their application, and from the staff of the Division of Certificate of Public Need who evaluated the proposal. I have considered the recommendation issued by the board of directors of the Central Virginia Health Planning Agency (CVHPA).

Based on my assessment, I have concluded that the application submitted by MRMC and MASC to establish a six-operating room outpatient surgical hospital in Hanover County merits approval and should receive a certificate of public need (COPN), subject to the following two conditions, as authorized by Virginia Code Section 32.1-102.2 C, *viz.*:

Condition One. That MRMC and MASC will provide outpatient surgical services to all patients without regard to ability to pay. This obligation may be satisfied by

(i) Providing free services to persons at or below 100 percent of the federal poverty level who have no third-party health care coverage;

(ii) Providing free or reduced-charge services to persons above 100 percent of the federal poverty level and at or below 200 percent of the federal poverty level who have no third party health care coverage; or

(iii) A combination of these two approaches. MRMC and MASC will also make good faith, reasonable efforts to encourage similarly-beneficial consideration of patients' financial circumstance by associated physicians and medical services.

Condition Two. That MRMC and MASC will provide annually to DCOPN and CVHPA an audited or otherwise certified financial statement documenting compliance with the preceding condition for the first three full, fiscal years following issuance of the COPN. The obligation to continue the provision of charity care at the level specified in the preceding condition, however, will continue beyond this three-year period.

The specific reasons for my recommendation include:

(i) The project proposed by MRMC is generally consistent with the most recent applicable provisions of the SMFP, and would be highly consistent with intended amendments to the SMFP designed to codify the specific consideration of institutional need for additional surgical services;

(ii) The project promises unique benefits due to its location on the campus of an acute care general hospital – the only one that will exist in Virginia.

Respectfully submitted,

Douglas R. Harris, J.D.
Adjudication Officer